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ABSTRACT

The purpose of this guide for educators is to provide strategies that schools can adopt to discourage teenage pregnancy. The first section describes adolescent pregnancy in New Jersey, including education efforts to address adolescent pregnancy, and statistics on adolescent fertility. The second section addresses familial, media and peer effects on adolescent sexual behavior, and includes a summary of the research. The third section compares adolescent sexual behavior and academic achievement. Student dropout statistics and characteristics are presented, then student aspirations, motivations and academic achievement are discussed as they relate to sexual behavior. Section 4 presents recommendations for school implementation, targeting key areas for program development and implementation. These include: (1) school leadership; (2) curriculum enhancement; (3) social service linkages; (4) after-school activities and programs; and (5) parent education. Adolescent pregnancy advocacy organizations and prevention programs are listed in appendices. (LLL)

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Preventing Teenage Pregnancy

What Educators Need to Know

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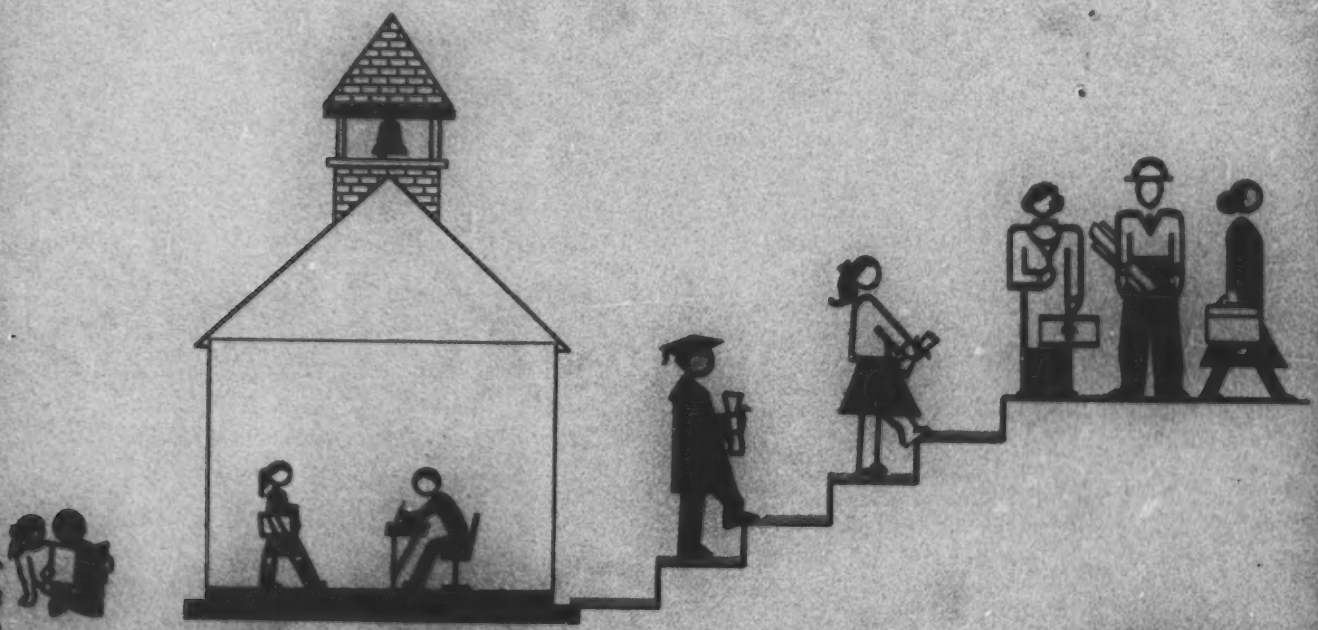

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Division of General Academic Education
New Jersey State Department of Education

PREVENTING TEENAGE PREGNANCY: WHAT EDUCATORS NEED TO KNOW

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FOREWORD

Educators daily face the problem of improving academic learning for children who are confronted with perplexing social issues. Teenage pregnancy is and always has been one of those social issues that interferes with student academic achievement. The educational community, acutely aware of the negative impact of early pregnancy on that child's future success and preparation for adulthood, can begin to establish prevention strategies by understanding and targeting factors contributing to early sexual activity and subsequent pregnancy.

The purpose of this document is to provide strategies that schools can adopt to discourage adolescent pregnancy and maintain their primary goal, which is to prepare children to be responsible, contributing adult citizens by helping them to complete their secondary education. I encourage you to give these issues your serious attention.

John Ellis

John Ellis
Commissioner

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INTRODUCTION

Over 1 million young women under age 20 became pregnant in the United States in 1985. Nearly one half million gave birth, and the remaining numbers either miscarried or terminated their pregnancies (Henshaw, Kenney, Somberg, & Van Vort, 1989). Each year, eleven percent of females ages 15 to 19 are becoming pregnant, with five percent of this number giving birth.

It is difficult for students of any age to continue their education while parenting and meeting the demands of raising a child; yet girls in New Jersey are becoming pregnant as early as the fourth grade. These children who become parents at such young ages find themselves encumbered with childrearing responsibilities before they have completed their own childhood and schooling.

Early pregnancy interferes with completing the developmental tasks of childhood and adolescence, such as forming a stable identity, having confidence in one's ability to form relationships with peers, and becoming less dependent on one's parents. According to Bolton (1984),

> These tasks are doors that must be passed through in sequence for normal development to occur. Often, if these doors are closed during appropriate transitional periods, they may never be open to the individual again. (p. 144)

Teenage pregnancy causes students to take a different life path which separates their developmental course from that of their fellow students and deprives them of experiences that contribute to their preparation for parent and adult roles. When early pregnancy interrupts that developmental life course, it limits the opportunities of these young parents, which affects not only their prospects but those of their offspring.

Educators should be concerned because these early pregnancies may indicate that children do not view completing their education as the primary means of achieving the economic security and self-sufficiency necessary for adult success. Without education, the children are faced with the decreased possibility of gainful employment and increased potential for perpetuating a cycle of poverty (Pitman, 1985). Educators, however, should be concerned not only with these broad issues of economic self-sufficiency but also with the practical consequences of early pregnancy. Early adolescent childbearing increases the likelihood of infant mortality or of low birth-weight babies who are likely to develop learning disabilities requiring special services. All of these problems contribute to isolating teen mothers from the mainstream of society.

Teenage pregnancy is a multifaceted problem which affects the health and mental health, as well as the economic and education status of the families involved (Pitman, 1985). The public school system, which is the sole institution serving the majority of children in this country, can undertake some preventive measures to address the problem. Among these are strategies for providing family life education, including human sexuality, at the

elementary and middle school levels; incorporating collaborative approaches with health and social service agencies into the school program; increasing parent involvement; and providing the educational supports for adolescents to stay in school and delay sexual activity.

Preventing Teenage Pregnancy: What Educators Need to Know is designed to support district efforts to develop and implement programs that incorporate these strategies. It includes current health data that indicate the extent and nature of the problem of teenage pregnancy in New Jersey, as well as critical factors that influence adolescents' decision to engage in sexual behavior. It also includes a discussion of how schools can help to reduce teenage pregnancy and provides lists of publications and programs as resources.

I. ADOLESCENT PREGNANCY IN NEW JERSEY

Educational Efforts to Address Adolescent Pregnancy

During the 1960s and 1970s, there were more teenage parents than ever before. This increase was a result of the "baby boomers" reaching childbearing age, thus increasing by 25 percent the total pool of young females capable of bearing children (Weatherly et al., 1985). During this period, legalization of abortion and social support for family planning occurred.

During this period, too, the United States Government recognized the severity of the problem of teenage pregnancy and commissioned many reports to focus on the problem. The data indicated serious health problems associated with early childbearing:

- low birth weight
- infant mortality
- increased welfare dependency

Studies also identified the impact of poverty on teenage pregnancy. The increased numbers of adolescents engaging in early sexual activity and childbearing caused changes in social policy related to public health services and educational programs. Under Title X of the Public Health Service Act, funding for new programs increased, yet the early federal programs stressed services over prevention (The Adolescent Health Services and Pregnancy Prevention Act, 1978).

Title IX and N.J.A.C. 6:4-1.1 et seq. was established to provide equal educational opportunity for all children, including pregnant and parenting adolescents. However, according to Zellman (1981), this was done "even at the expense of the exercise of the schools' moral training function" (p. 3). Although the legislation was instrumental in changing school attitudes toward pregnant and parenting students, questions remain as to whether these attitude changes stemmed from wanting to help this population comprehensively in the educational setting or from simply accepting its circumstances as a given. Title IX does benefit pregnant adolescents by ensuring that they receive an education comparable to that provided for their peers; yet it does not offer specific guidance for schools to use to cope with and address the problem, nor does it provide incentives for schools to serve these students fully. An additional deterrent for schools is the notion that to do something about the problem is to acknowledge that the problem exists, which can be viewed as an acknowledgment of school failure (Zellman, 1981).

During the 1960s and 1970s, New Jersey, along with two other states and many cities, adopted sex education curricula. Some educational communities assumed greater leadership in this area as the research emerged on the negative impact of teenage pregnancy on the education and social systems. Federal and state appropriations were increased to address the health and employment issues created by this population. Illinois appropriated $11 million for primary prevention and ameliorative services in 1981; Maryland commissioned a "Call to Action" study and established a state task force in

1984; and the New York legislature allocated $5 million for coordinated comprehensive prevention programs for at-risk communities.

One reason for the adoption of New Jersey's Family Life Education (FLE) mandate was to respond to adolescent pregnancy, as well as to other social and educational issues. When the state board endorsed the implementation of FLE, it did so, in part, for the following reasons:

- Appropriate information concerning sex education in schools is lacking; and family life education is being learned through commercial films, television, magazines, popular music, and from peers.

- Between 1965 and 1980, the percentage of out-of-wedlock births has nearly doubled.

Since that time, the numbers of pregnancies within subgroups of the teenage population have shifted, which heightens concern and bears further analysis.

New Jersey Statistics on Adolescent Fertility

Of all births in New Jersey in 1988 (the most recent statistical year reported by the Department of Health), nine percent were to adolescents. This percentage represents 10,472 births to girls between the ages of 10 and 19; 234 births to girls ages 10 to 14; and 10,238 births to those 15 to 19.

Since 1960, the rate of fertility per 1,000 15- to 19-year-old females has dropped significantly; however, among children in the 10- to 14-year-old age range, the rate of fertility has increased overall during this same 28-year time period (see Table 1).

TABLE 1

Adolescent Fertility Rates in New Jersey*
For selected years

YEAR	15-19	10-14
1960	58.2	0.54
1965	53.9	0.63
1970	49.8	0.85
1974	41.1	0.89
1975	34.4	0.89
1980	35.0	0.98
1981	32.84	0.96
1982	33.81	0.87
1983	33.39	0.96
1984	33.93	1.05
1985	33.99	0.92
1986	33.75	0.91
1987	34.41	1.01
1988	36.69	0.93

* Births per 1,000 females

Source: New Jersey State Department of Health (1989)

Figures 1 and 2 show the fertility trend for both of these age groups.

Figure 1

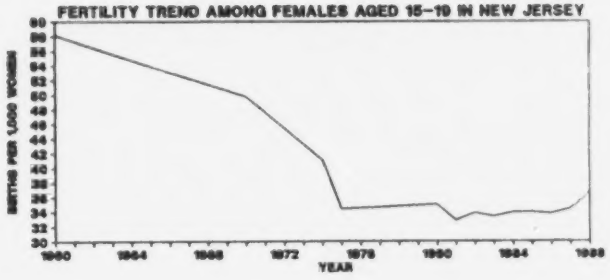
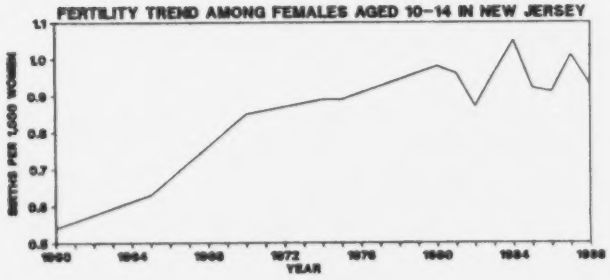


Figure 2



Although the pregnancy rate for 10- to 14-year-old girls is alarming, a comparison of the increase of pregnancies <u>across</u> age groups is equally startling. Table 2 shows that in any given year the number of births increases in geometric progression in each succeeding age group.

TABLE 2

Number of Births by Age and Year in New Jersey

YEAR	14	15	16	17	18	19
1988	234	531	1,223	2,107	2,907	3,450
1987	272	584	1,302	2,004	2,772	3,453
1986	246	623	1,242	1,815	2,709	3,533
1985	242	640	1,177	1,865	2,777	3,490
1984	276	574	1,196	1,857	2,779	3,612
1983	262	597	1,275	2,122	2,924	3,699
1982	246	627	1,313	2,124	3,173	3,826
1981	281	609	1,308	2,100	3,031	3,804
1980	292	659	1,402	2,284	3,190	4,060

Source: New Jersey State Department of Health (1989)

The number of teen pregnancies is increasing disproportionately in some areas of New Jersey. In response to this disparity, the New Jersey State Department of Health has targeted Maternal and Child Health Block Grant funds

TABLE 3

Fertility Rates*
for All Females Aged 10-14 Years,
by County, New Jersey, 1988
Ranked in Order of Fertility Rate for All Females

County	All Females	White	Nonwhite
Cumberland	3.27	2.51	5.75
Mercer	2.75	0.96	6.73
Atlantic	2.61	0.61	8.81
Salem	2.10	0.00	6.44
Passaic	1.46	0.91	3.24
Essex	1.39	0.43	2.23
Camden	1.35	0.68	3.33
Hudson	1.23	0.61	2.93
Warren	1.02	1.05	0.00
Cape May	0.76	0.42	4.13
Gloucester	0.76	0.28	5.02
Monmouth	0.64	0.12	4.07
Union	0.59	0.10	1.68
Middlesex	0.46	0.18	1.54
Burlington	0.45	0.28	1.13
Somerset	0.44	0.17	2.41
Hunterdon	0.31	0.32	0.00
Ocean	0.23	0.16	1.44
Morris	0.07	0.08	0.00
Bergen	0.00	0.00	0.00
Sussex	0.00	0.00	0.00
STATE	0.93	0.38	2.81

*Births per 1,000 females

Source: New Jersey State Department of Health (1988)

Tables 3 and 4 show the fertility rates for both groups by county in ranked order of fertility rate for all females.

Administrators should use these data to develop a profile of their student population, considering the following issues raised by these statistics:

- the number of births to girls age 14 and younger;
- the correlation between pregnancy and each specific age group;

to the counties with very high adolescent fertility rates. The rural counties of Cumberland and Salem and the urban counties of Atlantic, Camden, Essex, Hudson, Mercer, and Passaic are receiving these funds.

TABLE 4

Age-Specific Fertility Rates* for Females Aged 15-19 Years, by County, New Jersey, 1988 Ranked in Order of Fertility Rate

County	All Females	White	Nonwhite
Cumberland	79.14	60.05	139.26
Atlantic	66.94	45.76	156.70
Essex	58.45	30.95	83.19
Camden	58.38	41.41	110.72
Salem	57.01	33.78	127.08
Passaic	54.76	37.80	107.51
Hudson	51.72	38.98	84.88
Cape May	48.42	41.36	116.54
Mercer	43.00	20.42	105.83
Union	36.86	22.00	66.94
Gloucester	35.15	29.27	82.69
Burlington	29.81	25.74	42.89
Ocean	27.84	24.79	78.32
Warren	26.57	25.86	32.61
Monmouth	26.55	17.76	83.82
Middlesex	21.59	18.78	35.33
Somerset	17.13	12.15	57.89
Hunterdon	10.70	10.66	12.35
Sussex	10.59	9.71	20.41
Morris	9.89	8.90	20.79
Bergen	8.52	6.77	17.67
STATE	36.69	24.35	79.65

*Births per 1,000 females

Source: New Jersey Department of Health (1988)

- the disparity of birth rates among white and minority populations; and
- the disproportionate number of pregnancies in specific counties.

If schools examine these issues, they can find better ways to delay pregnancy and to increase educational attainment by developing collaborative relationships with health and social service agencies in their communities.

Although statistics for each municipality have not been reported, the county fertility rates are a starting point for analyzing the extent of adolescent pregnancy within each school district. Particular attention should be paid to disparities of birth rates among white and nonwhite populations and across different age groups.

The specific fertility rates for 10- to 14-year-old white and nonwhite females, for example, indicate that nonwhite females have a fertility rate almost seven times that of whites and more than two times the state average for all women for 1988. For girls 15- to 19-years-old, the fertility rate for nonwhites exceeds the state average by 135 percent and the rate among whites by 250 percent for the same year (see Tables 3 and 4). Nationally, for all age groups, nonwhite teens are twice as likely to become pregnant as white teenagers.

II. THE FAMILIAL, MEDIA, PEER ATTITUDE IMPACT ON ADOLESCENT SEXUAL BEHAVIOR

The adolescent years are frequently referred to as the "transition" years in which young people begin to replace early childhood roles with more adult roles. Generally, they begin to:

- assume more independence from parents (Brown & Newcomer, 1984);
- develop relationships with the opposite sex and initiate dating (Thornton & Camburn, 1986); and
- develop personality and sexual identities, which are influenced by the contemporary youth culture norms and the media (Sprafkin, Silverman & Rubinstein, 1980).

The foundations laid in the dependent early childhood years determine how successfully the teen will negotiate the transition to independency in adulthood. Negotiating these transition years requires decision-making skills that develop from a variety of experiences that are typical of the life of a teenager. This chapter presents findings that address the influence of families, the media, and peers on adolescents' sexual behavior, knowledge, and attitudes.

A. Family Impact on Adolescent Sexual Behavior

The family is central in the formation of children's sexual attitudes and behaviors because members act as role models and provide standards of individual and group behaviors. Views concerning responsible sexual behavior and the ways in which parents transmit and reinforce these are key determinants of the child's later behavior. In a longitudinal study on the Family and Institutional Factors in Adolescent Sexuality, Thornton and Camburn (1986) analyzed 20 years of data from adolescents and families in the Detroit area and found that while adolescents tend to be less conservative than their parents, basic attitudes regarding sexual behavior are similar. The study also found that the quality of parent-child relationships determines the degree to which parental attitudes influenced the attitudes and behaviors of their children.

In a study by Furstenburg et al. (1985), parents were grouped on a continuum as to whether they held traditional, moderate, or liberal views. This study explored whether parent's views and the quality of parent-child discussion and supervision affected the incidence of teenage sexual activity. The findings were that when parents who held traditional values discussed sex with their children, only three percent of their daughters reported having intercourse, whereas when these parents failed to communicate, 20 percent of the daughters reported having intercourse.

Other findings in the study were that:

- Among those daughters of parents who had liberal views and who did not communicate, 17 percent reported having sexual intercourse, whereas 21 percent with liberal parents who did communicate reported such experience.

- Young men consistently reported more permissive sexual attitudes and behaviors than young women.
- Sons of traditional parents indicated less incidence of sexual activity if parents generally listened and cared.
- When traditional parents talked with their sons about sex, the talks usually occurred after some sexual activity had been experienced.
- A mother's employment outside the home by itself had no discernible effect on her children's sexual attitudes.

Peterson, Moore, Furstenburg, and Morgan (1985), who studied the antecedents of early premarital intercourse in interviews with 11- to 16-year-olds, found that the rate of sexual activity was higher among children whose families were headed by a single parent. They speculated that the higher rate of sexual activity might be accounted for by the reduced parental monitoring of the child and an available unsupervised setting when that parent was at work.

Based on these research findings, two conclusions can be drawn on the impact of the family on adolescent sexual behavior. When children are given no messages or limited messages about their sexual activity, they lack the basis for forming responsible sexual decisions, and limited parental monitoring of the child's behavior provides an opportunity for engaging in sexual activity.

B. Media Impact on Adolescent Sexual Behavior

The growth of information technology has increased the knowledge of everyone, including children. Children are exposed to adult information which in the past was hidden from them and formerly distinguished them from adults. According to Elizabeth McGee (1982), the media reflect this dramatic change in our society:

> Madison Avenue's aggressive sexual sell, the influence of the sexual revolution, and the decline in the boundaries between the sexes increase the availability of places for teenagers to participate in sexual activity. (p. 9)

Television programming, for example, has become more sexually explicit than ever, with little attention given to the risks and responsibilities involved in sexual activity. Marie Winn (1983) points to the increasingly sexually explicit soap operas and popular music that children see and hear as unheard of phenomena in the past. Postman (1982) argues that such early access to information, once clearly delineating children's passage to adulthood, has shortened the transitional adolescent years, thus making the age category of adolescence less defined today than it was in the past.

A study (Brown & Newcomer, 1984) of the relative influence of parents, peers, and the media on the early sexual behaviors of adolescents, ages 12 to 15, revealed that:

- Television viewing was a weak predictor of whether sexual activity would be initiated.

- The more frequently an adolescent selects sexual content on TV the more likely the adolescent is to have had sexual intercourse. This finding held across racial and sexual groups regardless of the perceived encouragement for sexual behavior from either their best male or best female friends.

- Television viewing was suggested to have an effect on sexual behavior when programs served to: initiate or model; "disinhibit" existing behavioral tendencies; provide inaccurate information, ideas, or behavioral scripts that socialize children; or encourage sexual activity to effect catharsis or the release of feelings or tension.

- Most sexual behavior portrayed on television is between unmarried people.

- The study found a slight correlation between television viewing and sexual activity among those young people with lower intelligence and limited aspiration and without parental monitoring or interpretation of television programs.

- Older adolescents spend about three hours a day watching television, and younger ones, about four hours.

Television and popular music are not going to change in the near future. However, understanding that the media are a significant influence on children can arm parents and educators to diminish its impact. Parents can be encouraged to limit children's viewing and explain when behavior on television is not realistic and/or acceptable. Also, children should know that they can control personal behavior. Schools can and should emphasize these points to help children develop critical viewing skills.

C. Peer Impact on Adolescent Sexual Behavior

In 1985, Robert Coles and G. Stokes conducted a large survey of "the children of the children of Woodstock" on their sexual behavior. These researchers found that 50 percent of the boys had engaged in sexual intercourse before age 13, whereas 18 percent of the girls had experienced intercourse by that age. Among female adolescents, the largest group, or 32 percent, had had sexual intercourse by the age of 15 (Coles & Stokes, 1985).

Finkel and Finkel (1981) investigated the age of first sexual intercourse among boys and found a disparity among these cohort groups. The mean age at first coitus for black males was 11.6 years; for Hispanic males, 13.0 years; and for white males, 14.5 years. However, this disparity among the races and sex groups must be viewed in the broader context of ethnic culture, family, and socioeconomic factors. What is more, in spite of the disparties, these studies all identify that large numbers of our youths, regardless of gender or of ethnic group, are initiating sexual activity at an early age when they usually are not socially or intellectually prepared to handle the consequences. To compound this situation, Marsiglio and Mott (1986) found in

their study, using information from the National Longitudinal Survey of Work Experience of Youth, that "large proportions of teenagers initiated coitus before they had taken a sex education course" (p. 151).

Students spend a significant amount of time with their peers. These groups usually share the same views and outlooks on life as well as support each other's decisions. For this reason, peer groups are believed to exert a great deal of influence on individual members, thus affecting their individual decision making. Studies referenced below demonstrate how much of an influence peer groups have.

If students are having sexual intercourse at a young age, they are also influencing or being influenced by someone to participate. Dating can influence students' sexual behavior. The timing of the initiation of dating is related to the onset of first sexual activity. Early dating experience increases the likelihood of early first coitus (Thornton, 1986). In evaluating the attitudes of parents and children toward sexual permissiveness, Thornton reviewed courtship practices and drew the following conclusions:

- Early dating increases the likelihood of developing steady relationships.
- Early dating increases the frequency of dating.
- As the relationship becomes more involved, "the range of sexual experience that is normatively acceptable expands" (p. 206).

In their research on peer influence on sexual behavior, researchers Brown and Newcomer (1984) completed a longitudinal study of seventh, eighth, and ninth graders. This study was unique because the interviews were conducted with triads composed of the student, a best male or female friend, and a parent. The researchers were interested in determining who had the most influence in encouraging the respondent to learn things about sex, teaching the respondent things about sex, encouraging the respondent to be more sexually active, and encouraging the respondent to be less sexually active.

The findings were:

- There was no significant difference in the degree of influence of a friend if one was sexually active and the other was not. Virgin girls retained their virginity status even when the friend was sexually active.
- Teenagers generally appeared to make accurate assessments of their friends' attitudes toward sex. If teens believed that non-adult sex was bad, they chose friends who held the same attitudes.
- Adolescent male attitudes toward sex, however, generally were misunderstood or misperceived by both their male and their female friends.
- Adolescent male and female friendships may be more a reflection of the groups with which the teens identify than of sexual attitudes.

- Adolescent girls who had had intercourse engaged in more sexually motivated activities to influence their inexperienced male friends to engage in sexual activities.

- Mothers who did not communicate their sexual attitudes to their sons were twice as likely to have sons who had intercourse at a younger age.

- The influence of the parents' attitude toward sexual behavior was similar to that of their child's best friends, i.e., parental and child attitudes were similarly congruent.

According to Alwin (1986), children tend to select friends based upon similarities between these friends and themselves. Those who are chosen are likely to be not only academically similar, but "more similar to oneself in sexual activity than dissimilar" (p. 100). Discouraging sexual activity reinforces the behavior of those students who choose to delay and increases the number of students who believe that delaying sexual activity is important for school completion.

D. Summary of the Research

- Communication between parent and child on sexual attitudes and beliefs has more of an impact on adolescent sexual behavior than the religious beliefs of traditional, liberal, or conservative parents.

- Communication between parents and male children happens most frequently after the male child has become sexually active.

- Employment of mothers does not appear to have an effect on children's sexual attitudes or behaviors. The degree of supervision and the amount of "free" time an adolescent has does have an effect by providing an environment conducive to sexual activity.

- Although television programming has become more sexually explicit, particularly in depicting sexual activity between unmarried couples, the degree of supervision of television viewing can have a controlling effect. Misleading attitudes may be corrected when a supervising adult is present.

- Adolescents who appear to have decided to delay sexual activity are more likely to have higher academic achievement goals and aspirations.

- There is a relationship between the amount of television viewing and lower intelligence, limited aspiration, and a lack of parental monitoring.

- The amount of time spent on television viewing is higher for younger adolescents than older. Older adolescents have a broader array of other activities to engage in, i.e., employment.

- Adolescent girls appear to have accurate perceptions of their friends' sexual attitudes and behavior, selecting friends with

similar attitudes, which minimizes the degree of pressure to become sexually active.

- Adolescent males appear to be unaware of or inaccurate about their male friend's attitude toward sexual behavior. This may be due to communication patterns between males that discourage accurate communication about sexual activity.

- The age disparity between white and minority initiation of sexual activity may reflect minority feelings of alienation and perceived lack of life chances in mainstream society.

- Parents' attitudes toward sexual behavior were similar to those held by their children's friends. Although adolescence is a period of striving for independence from parents, adolescents may still want the security of their parents' acceptance of their sexual attitudes.

Kurt Lewin considered adolescence as the transitional phase between childhood and adulthood when essentially a change in membership groups occurs (Muuss, 1982). The child is synthesizing new psychological and social experiences within the context of a rapidly changing body, moving from the familiar to the unfamiliar without the benefit of a cognitive structure to make this adjustment.

The body is changing and creating the possibility for new behaviors, including sexual behavior. A change in body image, notwithstanding the hormonal changes, accompanies this development. The family reacts to these changes reflecting its cultural context. Therefore, we have gender-specific development, maturation, and physiological development, in addition to familial and peer interactions, contributing to personality formation. Adolescence is a transitional period during which the pieces of a large puzzle are being put into place.

III. ADOLESCENT SEXUAL BEHAVIOR AND ACADEMIC ACHIEVEMENT

A. Student Dropout Statistics and Characteristics

There is a growing population of students who are at risk of failing and dropping out of school. According to New Jersey's 1989-1990 Vital Education Statistics, Vol. 1 (1990), a mere 442 students were reported to have dropped out of school for reasons of pregnancy or marriage when a total of 6,683 females dropped out of school, some for unknown reasons. However, these statistics may not reflect the actual number of female dropouts since approximately 6,000 New Jersey school-age students become pregnant annually.

Michelle Fine's (1985) study of New York City dropouts revealed that 30.7 percent of the female dropouts claimed they were getting married or were pregnant. Nationally, 40 percent of teenage girls drop out of school for the same reasons (Children's Defense Fund, 1988).

Fine's study provides a profile of these youngsters that reveals certain common experiences:

- They are from low socioeconomic families living at or below the poverty levels.
- They have unmet psychological needs and developmental problems.
- They have low self-esteem and feelings of disconnectedness from the schooling process and life success.
- They are predominantly minority children.

B. Student Aspirations, Motivations, and Academic Achievement Related to Sexual Behavior

Children of all races, genders, and/or socioeonomic circumstances need to be helped to see the advantages of delaying sexual activity and parenthood for achieving positive life goals.

> It is important that schools understand that girls will delay sexual activity, or reliably use contraceptives if they are sexually active, when they perceive that the completion of their education has major implications for future life success. (Woolis & Mellow, 1986, p. 2)

In his study correlating educational aspiration and sexual activity, Duane Alwin (1986) interviewed mothers and their 18-year-old children in over 900 families. The results were:

- "Higher educational aspirations characterized those persons who were not yet sexually active" (p. 105).
- "Educational plans are importantly linked to grades and curriculum placement" (p. 105).

- Virgin teens were "twice as likely to have been in a college preparatory curriculum than those whose sexual activity began prior to age 15" (p. 105).

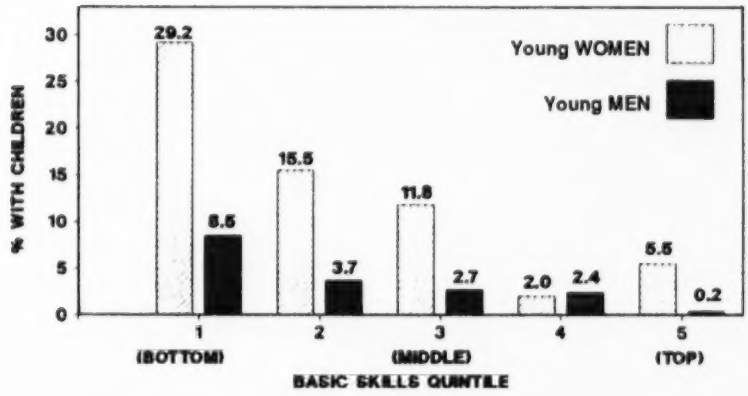
- Teens "experiencing college preparatory curriculum with better grades during high school" (p. 105) had lower frequencies of sexual activity.

- "Among females, frequent sexual activity reduces educational plans" (p. 111).

Figure 3 shows the basic academic skill levels of 18- and 19-year-olds who were parents.

Figure 3

Percentage of 18- and 19-Year-Old Males and Females Who Were Parents in 1981, by Basic Skills Level*



As Figure 3 indicates, girls and boys who perform poorly in basic skills are three times as likely to have children as those whose basic skills performance is average.

In Sex and Pregnancy in Adolescence, Zelnick, Kantner, and Ford (1981) report that female students between 15- and 19-years-old who consider high school graduation as their terminal educational goal were twice as likely to have had sexual intercourse as those who sought higher education. Karen Pittman (1986) reports from the data of the National Longitudinal Survey of Young Americans that "teenagers with poor basic skills are far more likely to become parents at an earlier age than those with average or

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above-average academic skills" (p. 4). The kinds of expectations that adults and school staff may have communicated either directly or indirectly to children have implications for students' academic achievement and future planning.

Peterson et al. (1985) studied early sexual behavior and found three familial factors contributing to it. Female-headed households, family attitudes about future aspirations in life, and different sexual norms for males and females all were contributing factors. Further, they found that adolescents who received information on appropriate sexual attitudes participated actively in religious programs and sustained a sense of the future, delaying sexual activities.

In a different type of study, one that has implications for the issue of adolescent pregnancy, Shimahara (1983) studied social polarization in the high school. His hypothesis was that the school assigns occupational roles, student placement, and status through a structure that reflects the larger society. The school is the socializing agency that prepares children for the transition from childhood family dependency to adult independence. The life course charted for the child by the school is usually irreversible, especially if the child is rewarded or negatively reinforced by all involved: teachers, administrators, parents, and peers. Many times these life courses are predetermined based upon perceptions of the child's abilities, potentials, family background, socioeconomic level, heritage, culture, and many other attributes or "labels" that have nothing to do with the school's job of academic instruction. These perceptions reinforce the school's expectations.

Shimahara's study has implications for schools that reinforce a stratified, ability-grouping structure for students. This tracking schema has serious long-range educational implications because if students feel that they are not expected to succeed in school, they may turn to alternative behavior, for instance, sexual behavior.

Chilman, in Adolescent Sexuality in a Changing Society (1983), cautions us to avoid making the wrong assumptions about the causes of early pregnancy. School failure may stimulate behaviors leading to early pregnancy rather than early pregnancy contributing to dropping out of school. This cause and effect relationship provides the rationale for early identification of students that have been identified as "at-risk," "marginal", or "vulnerable." Those children identified as low-achievers, experiencing school failure and having limited expectations for a better future, are prime candidates for adolescent pregnancies. Furthermore, great numbers of these students drop out of school as a result of unmet psychological needs. All children need to experience success. In its absence, they may turn to alternative indicators of success, the symbols of adult status. According to N.J.S.A. 9:17A-1, pregnancy accords a minor female that status in entitling her to give consent to medical care for herself and her child. If these "new" adults have not successfully negotiated the traditional route to adulthood, can we expect them to impart the values of that route to their offspring...our future students?

IV. RECOMMENDATIONS FOR SCHOOL IMPLEMENTATION

The research on adolescent pregnancy summarized in this document identifies key areas to be targeted for program development and implementation. These areas are:

- **Early age of coitus**
- **Frequency of sexual activity**
- **Family influence on sexual behavior**
- **Peer influence on sexual behavior**
- **Sources of sexual information**
- **Strengthening values toward educational attainment**

This section of the document will address these areas by recommending activities to create and strengthen programs and resources.

Chilman (1983) cautions against establishing general corrective programs based on the assumption that all teenagers have identical characteristics and needs. Each adolescent's needs must be assessed and an appropriate treatment program developed accordingly. It would be dangerous for us to stereotype all at-risk adolescents and assume that they will decide similarly to engage in early sexual behavior. Educational programs designed to prevent pregnancy must:

- diagnose the possible causal factors for each child;
- view the child as part of a larger social system that includes the family, the community, and the social services;
- develop the child's awareness of the consequences of personal behavior;
- develop a sense of responsibility;
- work on the unspoken causes -- motivational, attitudinal, and societal; and
- integrate family life education into all areas of the curriculum by incorporating decision-making strategies, while stressing the importance of school success.

All of the following recommendations are interrelated and should be viewed this way. However, first and foremost, administrators should examine their population and programs (both on a school and district level) through a survey or evaluation in order to determine the specific causes of the problem (see reference section). Administrative and teaching staffs, as well as community representatives and parents, should participate in this procedure.

Although a comprehensive approach to preventing adolescent pregnancy is multi-faceted, schools can effectively address the issue of building the

children's capacity to delay sexual activity within Family Life Education programs. Suggestions are organized under five categories, each of which includes an objective and recommended activities.

A. School Leadership

Objective: To reduce the incidence of adolescent pregnancy by improving and enhancing the educational climate.

The principal and chief school administrator should be involved in efforts to accomplish the following:

1. Present the facts about and signs of early sexual activity to teaching staff (see reference section).

2. Establish and communicate clear educational goals and expectations for the entire student body to entire staff, parents, the community, and the student population. There needs to be a clear understanding that school is a place where learning occurs and that everyone can and will learn. Also, school administrative leadership must reduce and eliminate forces in the school, such as discriminating behavior toward students by teachers and administrative staff, which act against student achievement and perpetuate a pattern of low expectations.

3. Specify and maintain school etiquette and appropriate school behavior because this not only promotes a more orderly school and classroom environment, but has a positive impact on social interactions outside school, which is important in achieving future endeavors. Extraneous student sexual behavior in the school environment, such as the use of offensive sexual language and gestures and the wearing of sexually provocative clothing, would be reduced.

4. Assess the past dropout patterns and community social condition in order to determine which approach the district should take to reduce the potential rate of school dropouts.

5. Know the community services available to the school. Frequently, school administrators are not aware of the support available to assist them with student-related health or social service needs.

6. Be attuned to the ways in which students and parents handle pregnancy. Often, school staff may not be aware that a student is pregnant because the child and/or parent may have addressed the problem before it became observable. School administrators, nevertheless, should be sensitive to the personal and confidential nature of the issue and use caution to avoid being intrusive.

B. Curriculum Enhancement

Objective: To reduce the incidence of adolescent pregnancy by implementing a curriculum that promotes knowledge and understanding of sexuality and related issues.

The school district should incorporate the following topics and program efforts into its Family Life Education curriculum, as needed.

1. The introduction of the topic of sexuality and responsible sexual behavior at or before fourth grade can instruct children about their bodies before puberty and sexual activity commence.

2. Knowledge of child abuse, including sexual assault prevention, may also prevent incest. Although it has not been fully substantiated, clinical professionals suspect that sexual abuse of children or incest may be the cause of pregnancies before age 14.

3. Assertiveness training may discourage acceptance of traditionally assigned female and male behaviors, i.e., female passivity and male aggressiveness, that are destructive.

4. Knowledge about how to withstand sexual exploitation and date and acquaintance rape can also assist in preventing sexual assault.

5. Postponing Sexual Involvement, a nationally recognized program developed by the staff at Emory University Medical School and Grady Memorial Hospital Teen Services Program in Atlanta, Georgia, is a prevention approach. Designed for 12- to 14-year-olds, this assertiveness, awareness program helps children resist peer pressure to engage in early sexual activity.

6. Future-planning curricula help. Such curricula are designed to help children understand how their schooling prepares them for the future and why they should delay early sexual involvement and adolescent pregnancy. In New Jersey, the Bayonne, Clearview, Montgomery, Moorestown, and Ridgewood public schools instruct children on the negative impact of early sexual activity and parenting on their futures (see reference section).

7. Discussing myths is important. As an example, it is a common myth among young people that a virgin cannot get pregnant during first intercourse. Discussing these myths within the curriculum can reduce or eliminate areas of uncertainty and misinformation for children.

8. Career education is another way to build the capacity in children to plan for a positive future.

C. Social Service Linkages

Objective: To reduce the incidence of teenage pregnancy and early sexual behavior through cooperative social service prevention activities.

The following activities and programs represent joint activities between the schools and social service and medical service agencies.

1. School-based Health Clinics. Clinics based in schools provide a valuable medical resource, particularly for children who have poor

health care histories. In this country, 61 public school sites provide primary health care services, including physical exams, health career programming, gynecological examinations and information, and in a few clinics, the administration of prescription birth control (Lovick & Wesson, 1986). Most centers, operating from one to five days a week, are sponsored by hospital/medical centers or departments of health.

School-based health clinics require parental consent before a child can receive medical care. Further, clinics encourage parental participation in an advisory capacity. In terms of family planning services, 52 percent of clinics offer counseling, examinations, prescription contraceptives, and follow-up services. Twenty-eight percent dispense contraceptives in addition to the other services, and 20 percent refer students to family planning and offer counseling and follow-up services.

In addition, New Jersey has a school-based youth services program that is considered unique in that it provides more than health services, offering mental health, family, and employment counseling (see Appendix).

2. Improvisational Theater. In teen improvisational theaters, teens develop skits on a variety of subjects, such as the reasons for delaying sexual activity, places where young people can go for answers to questions or problems, the problems of early parenting, and child abuse. The student actors are a resource for their audience of children and parents. This is a peer-helping-peer type of program that is offered to provide a comfortable setting for sharing information (see Appendix).

3. Hotlines. Hotlines are another way to provide a comfortable and confidential source of information to children on reproductive health, as well as on other childhood concerns. Such hotlines can be established for limited weekly hours in a social service agency staffed by agency personnel or adult or student volunteers. This is an inexpensive way for children to obtain referral information.

4. Resources. Schools can develop and provide students with a list of the social and medical service agencies and respective telephone numbers. One organization supplied students at the beginning of the school year with attractive bookcovers which listed all of the social services agencies in the county. Additionally, agency representatives may serve as a resource for family life education.

D. After-school Activities and Programs

Objective: To reduce the incidence of teenage pregnancy by providing children with constructive and rewarding social activities.

Many unsupervised children are participating in recreational sexual activities to overcome boredom and to alleviate loneliness. When children

are unsupervised, empty homes provide a place for sex. Two ways in which schools can help combat this problem:

1. School-age Childcare. After-school programs are one way of providing care for children in the elementary and middle grades. Boards of education or community agencies can sponsor such programs in a nearby facility or in the school building.

2. Extracurricular and tutorial activities. After-school programs, such as clubs, special interest groups, and tutorial assistance, are ways in which schools or community agencies can constructively occupy the free time of children. If schools cannot provide these activities, they can fulfill family needs by notifying parents that community agencies do provide such activities.

E. Parent Education

Objective: To reduce the incidence of teenage pregnancy by strengthening the parent-child interaction.

Many parents do not discuss childhood and adult sexuality with their children. This may be a factor of their own discomfort and/or a lack of knowledge about their own, as well as their child's, sexuality. The following provides suggestions to facilitate parent awareness and involvement.

- Materials. Educators can give parents strategies for educating themselves and their children on human sexuality topics through handouts or bulletins. Handouts could be developed for parents to use at home to reinforce what their children are learning about Family Life Education (FLE) in school.

- Community Agencies. Local agencies have many resources that could supplement the educational activities of the school. The Department of Health and Planned Parenthood are such agencies that have developed printed materials for educating the public.

- Forums. Forums could be held for parents to receive current information on FLE. The forums should be held in community-based locations and offered at times when working parents can attend.

- Parent Meetings. Day care services should be offered when parent meetings are held, and strategies for encouraging the total family to participate would be helpful. Working parents, adolescents, and younger children could participate in one-day seminars offered on weekends.

- Community Cooperation. Business and industry could help to support the development of information packets for parents to offer at-home instruction on human sexuality topics.

- School Communication. Schools that respond to each parent's concern for his or her child's well-being can better engage parents in worthwhile, useful activities. Any approach that focuses on the strengths, rather than the weaknesses, of parents

will reduce their sense of inadequacy, defensiveness, and rebelliousness toward the school.

An example of a district approach to parent education in human sexuality is to be found in the Washington Township Public Schools in Warren County. Washington Township Public Schools hold evening programs for girls and boys, separately, with their respective gender parents. These programs, The Story of Menstruation and Boy to Man, promote discussion during the program, as well as at home, and provide resources for parents. In addition to these activities, the school takes parents on field trips to the Weller Institute for Health Education where they attend a program on human sexual development that their children will attend during a subsequent school field trip. The school also pays for parent subscriptions to the newsletter, Growing Up (see Flamer, 1987).

A list of adolescent pregnancy programs that assist pregnant and parenting adolescents is included in the Appendix. Districts can contact these programs directly for in-depth implementation and effectiveness information.

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CURRICULAR PROGRAMS

Postponing Sexual Involvement
Teen Services Program
Grady Memorial Hospital
P.O. Box 26158
Atlanta, Georgia 30335

A New Approach to Contraceptive Education
The Center for Family Life Education
575 Main Street
Hackensack, New Jersey 07601

Life Planning Education
Center for Population Options
1012 14th Street, N.W.
Suite 1200
Washington, D.C. 20005

Preventing Adolescent
Pregnancy Program
Girls Clubs of America
205 Lexington Avenue
New York, New York 10016

The Dynamics of Relationships
Equal Partners
11348 Connecticut Avenue
Kensington, Maryland 20895

Counseling
Teen Choice: Pregnancy Preventive Counseling
Inwood House
320 East 82nd Street
New York, New York 10028

DEMONSTRATION PROGRAM

Urban Middle Schools' Adolescent Pregnancy Prevention Program
Academy for Education Development (AED), School Services Division
680 Fifth Avenue
New York, New York 10019
(212) 397-0040

EVALUATION

Adolescent Parenthood: Developing a Comprehensive Community Guide Around the Issue of Teenage Pregnancy
Women and Foundational Corporate Philanthropy
70 West 40th Street
New York, New York 10018
(212) 460-9253

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TRAINING

Center for Early Adolescence
University of North Carolina at Chapel Hill
Suite 223, Carr Mill Mall
Carrboro, North Carolina 27510
(219) 966-1148

National Training Institute
The Center for Population Options, 101
1012 14th Street, N.W., Suite 1200
Washington, D.C. 20005
(202) 347-5700

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APPENDIX

APPENDIX A:

ADOLESCENT PREGNANCY ADVOCACY ORGANIZATION

NEW JERSEY NETWORK ON ADOLESCENT PREGNANCY
Rutgers University School of Social Work
Center for Community Education
73 Easton Avenue
New Brunswick, New Jersey 08903
(201) 932-8636

The New Jersey Network on Adolescent Pregnancy (NJNAP) is a program of the Center for Community Education in the Rutgers University School of Social Work. The Network, created in 1979, is a voluntary association of organizations and individuals focusing on the issue and ramifications of adolescent pregnancy. Activities of the NJNAP are carried out at the local level by county networks. The Network provides linkages among existing organizations, but is not itself a formal organization with membership as such. It consists of affiliates and subscribers who are seeking ways to share information and ideas; it provides a common focus on serving adolescents in need without limiting freedom and choice in the type of service provision; it emphasizes the enrichment of sharing and mutual cooperation, particularly during funding cutbacks; and it seeks to avoid duplication and competition. By mid-1986, almost 3,000 people had joined together in activities of the county networks.

The Rutgers office of NJNAP exists to provide services to county networks and their affiliate agencies, including schools. Rutgers provides technical assistance and consultation; a quarterly newsletter EXCHANGES; statewide and county resource directories; seminars, conferences, and training; a resource center of printed and audio-visual materials; and clearinghouse services on program and policy development and statewide planning to persons concerned about adolescent pregnancy, teen parenting, and related issues.

ETR ASSOCIATES
1700 Musseon Street, Suite 203
P.O. Box 1830
Santa Cruz, California 95061-1830

This organization publishes the journal Family Life Educator and coordinates the National Family Life Education Network.

APPENDIX B:

ADOLESCENT PREGNANCY PREVENTION PROGRAMS*

After School Programs

Center 54
Junior High 54 After School Program
107th Street and Columbus Avenue
New York, New York 10625

Teen Outreach Program
8346 Delcrest
St. Louis, Missouri 63124

Drop-out Prevention

Rich's Academy, based in Atlanta Georgia
Cities in Schools
1110 Vermont Avenue, N.W.
Suite 1120
Washington, D.C. 20005

Teen Improvisational Theatre

Family Circle Theatre
1202 Havenwood Road
Baltimore, Maryland 21218
(301) 366-0717
Contact: Kay Lawal, Director

SALT WORK
The Design Center
5001 Baum Boulevard
Pittsbugh, Pennsylvania 15213
(412) 687-8884
Contact: Lyn George

*Taken from Model programs: Preventing adolescent pregnancy and building youth self-sufficiency by Karen Pittman and Carrie Govan. Washington, D.C.: Children's Defense Fund, 1986.

Teatro Hey (Health Education for Youth Theatre Program)
Center for Population and Family Health
Columbia University
60 Haven Avenue
New York, New York 10032
(212) 305-6960 Ext. 62
Contact: Yvonne Carretero

TAP (Teen Advocacy Program)
Planned Parenthood of the Mercer Area
427 E. State Street
Trenton, New Jersey 08625

WAITT: Washington Area Improvisational Teen Theatre
Planned Parenthood of Washington, D.C.
1108 16th Street, NW
Washington, D.C. 20036
(202) 347-8500
Contact: Margaret Copemann, Director

WEATOC: We're Educators with a Touch of Class
25 Crawford Street
Dorchester, Massachusetts 02120

School Based Health Clinics*

The Support Center for School-Based Clinics
The Center for Population Options
5650 Kirby Drive, Suite 148
Houston, Texas 77005

Arizona
Arizona Department of Health Services
1740 W. Adams Street
Phoenix, Arizona 85007
(602) 255-1870

California
City/Co of San Francisco
Department of Public Health
101 Grove Street
San Francisco, California 94102
(415) 558-3684

Colorado
Valley Wide Health Services
204 Carson Avenue
Alamosa, Colorado 81101
(303) 589-5161

*Taken from School-based clinics: Update by Sharon Lovick and Wanda Ulson. Washington, D.C.: The Center for Population Options, 1986.

Connecticut

Greater Bridgeport Adolescent Pregnancy Program
179 Middle Street
Bridgeport, Connecticut 06604-4001
(203) 336-1331

Fairhaven Community Health Clinic
374 Grand Avenue
New Haven, Connecticut 06513
(203) 777-1411

Florida

Gadsden County Public Health
Department
P.O. Box 587
Quincy, Florida 32351
(904) 627-7521

Illinois

Cook Co. Public Health Department
Department of Pediatrics
700 S. Wood Street
Chicago, Illinois 60612
(312) 633-7438

Ounce of Prevention Fund
2 N. LaSalle, Room 605
Chicago, Illinois 60602
(312) 621-0566

Comp. Mental Health Center
St. Clair County
3911 State Street
E. St. Louis, Illinois 62201
(618) 482-7330

Indiana

Gary Community School Corp.
Roosevelt Ad. Health Project
620 East 10th Place
Gary, Indiana 46402
(219) 886-6502

Methodist Hospital of Indiana
1701 N. Senate Boulevard
Indianapolis, Indiana 46202
(317) 929-5348

Maryland

EPSDT School-Based Program
1211 Wall Street
Baltimore, Maryland 21230
(301) 396-3185

The Self Center
Johns Hopkins Adolescent
Pregnancy Prevention Program
405 North Caroline Street
Baltimore, Maryland 21231

Michigan
Hurley Medical Center
One Hurley Plaza
Flint, Michigan 48502
(313) 257-9503

Muskegon Area
Planned Parenthood
1642 Peck Street
Muskegon, Michigan 48441
(616) 726-6620

Minnesota
Minneapolis Health Department
250 South 4th Street
Minneapolis, Minnesota 55415
(612) 348-2884

St. Paul Adolescent Health Service Project
640 Jackson Street
St. Paul, Minnesota 55101
(612) 221-8876

Mississippi
Jackson-Hinds Comp. Health Center
4433 Medgar Evers Boulevard
Jackson, Mississippi 39213
(601) 362-5321

Missouri
Adolescent Resources Corp.
4010 Washington, #400
Kansas City, Missouri 64111
(816) 561-7097

New Mexico
University of New Mexico
Department of Pediatrics
Surge Building
Albuquerque, New Mexico 87131
(505) 277-5551

Pecos Valley Medical Center
P.O. Drawer 552
Pecos, New Mexico 87550
(505) 757-6482

New York
School Health Demonstration Program
Jamaica Hospital
8906 135th Street
Jamaica, New York 11418
(718) 657-1800

Mt. Sinai Hospital
Adolescent Health Center
19 East 101st Street
New York, New York 10029
(212) 650-7570

Bedford Stuyvesant Family Health Center, Inc.
1360 Fulton Street, 5th Floor
Brooklyn, New York 11216
(718) 636-4500

St. Luke's-Roosevelt Hospital
428 West 59th Street
New York, New York 10091
(212) 554-6616

Ryan Community Health Center Mid-Westside
Neighborhood Health Council, Inc.
160 West 100th Street
New York, New York 10025
(212) 678-5698

Ohio
Cleveland Student Health Program
1001 Huron Road
Cleveland, Ohio 44115
(216) 781-2944

Oregon
Jackson Co. Health Department
11313 Maple Grove Drive
Medford, Oregon 97501
(503) 776-7328

Multnomah Community Health Department
426 Southwest Stark
Portland, Oregon 97204
(503) 248-3674

Texas
West Dallas Youth Clinic
Children and Youth Project
3131 North Hampton Road
Dallas, Texas 75212
(214) 688-3108

Urban Affairs Corporation
1700 Gregg Street
Houston, Texas 77020
(713) 222-8788

New Jersey School-Based Youth Services Program

New Jersey State Department of Human Services
222 South Warren Street
CN 700
Trenton, New Jersey 08625-0700
(609) 292-7901

Atlantic County

Atlantic City Teen Services Center
West Side Complex
Dr. Martin Luther King, Jr. Boulevard
Atlantic City, New Jersey 08401
(609) 344-3111

Pleasantville Recreation Center
400 West Berlin Avenue
Pleasantville, New Jersey 08232
(609) 484-3675

Bergen County

Hackensack High School
First and Beech Streets
Hackensack, New Jersey 07601
(201) 646-7939

Burlington County

Pemberton School Based Program
Pemberton-Fort Dix Road
P.O. Box 246
Pemberton, New Jersey 08068
(609) 894-0170

Camden

Camden County Health Department
1800 Pavilion West
2101 Ferry Avenue
Camden, New Jersey 08104
(609) 757-8218

Cape May

Lower Cape May Regional
School District
687 Route 9
Cape May, New Jersey 08204
(609) 884-8641

Cumberland

Bridgeton School Based Youth
Services Program
Bridgeton High School
West Avenue
Bridgeton, New Jersey 08302
(609) 451-4440

Essex

Teen Powerhouse
91 West Market Street
Newark, New Jersey 07103
(201) 324-1990

Irvington Youth Resources Center
54 Mt. Vernon Avenue
Irvington, New Jersey 07111
(201) 372-1437

Gloucester

Gloucester County Vocational-
Technical School
P.O. Box 186
Tanyard Road
Sewell, New Jersey 08080
(609) 468-1445

Clayton Place
457 North Delsea Drive
P.O. Box 85
Clayton, New Jersey 08312
(609) 845-9431

Hudson

Emerson High School
318 18th Street
Union City, New Jersey 07087
(201) 392-3648

Bayonne School Based Program
Police Athletic League Building
24th Street & Avenue A
Bayonne, New Jersey 07002
(201) 858-7884

Hunterdon

Hunterdon Medical Center-CMHC
Route 31
Flemington, New Jersey 08822
(201) 788-6401

Mercer

Urban League of Metropolitan
Trenton
209 Academy Street
Trenton, New Jersey 08618
(609) 989-7535
(609) 989-4701

Middlesex

UMDNJ - Community Mental
Health Center
189 New Street
New Brunswick, New Jersey 08901
(201) 745-5306
(201) 745-5334

South Brunswick High School
Major Road
Monmouth Junction, New Jersey 08852
(201) 329-4044 Ext. 224

Monmouth

Long Branch High School
391 Westwood Avenue
Long Branch, New Jersey 07740
(201) 495-4995

Morris

Dover High School
Grace Street
Dover, New Jersey 07801
(201) 989-0540 (Site)
(201) 989-2017 (Summer)
(201) 989-2017 (School Year)

Ocean

National Council on Alcoholism
of Ocean County
East County Line Road & Ridge Avenue
Lakewood, New Jersey 08701
(201) 367-5515

Pinelands Regional High School
Nugentown Road
Tuckerton, New Jersey 08087
(609) 296-3106 Ext. 204

Passaic

Department of Human Resources
155 Market Street
Paterson, New Jersey 07505
(201) 881-3714

Passaic Public Schools
101 Passaic Avenue
Passaic, New Jersey 07055
(201) 470-5230

Salem

Salem County Vocational-
Technical Schools
Division of Special Needs
172 Salem-Woodstown Road
Salem, New Jersey 08079
(609) 935-7363

Somerset

Somerset County Vocational-
Technical School
P.O. Box 6350
North Bridge Street & Vogt Drive
Bridgewater, New Jersey 08807
(201) 526-8900 Ext. 26

Sussex

Sussex County Vocational-
Technical School
105 North Church Road
Sparta, New Jersey 07871
(201) 383-6700 Ext. 167
(201) 579-7725

Union

Youth Enrichment Service
St. Elizabeth Hospital
Department of Social Services
225 Williamson Street
Elizabeth, New Jersey 07207
(201) 353-4YES
(201) 527-5136

Plainfield Board of Education
Plainfield School Based Youth
Services Program
920 Arlington Avenue
Plainfield, New Jersey 07060
(201) 753-3156

Warren

Phillipsburg Middle School
675 Corliss Avenue
Phillipsburg, New Jersey 08865
(201) 454-3400 Ext. 317

READER FEEDBACK FORM

PREVENTING TEENAGE PREGNANCY: WHAT EDUCATORS NEED TO KNOW

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